DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 03-03

2. STATE: Nevada

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 8, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
CFR42, 447.200, 201 & 204

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ (2, 459, 786)
b. FFY 2005 $ (2, 707, 259)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Assurance 4.19B, page 1
Attachment 4.19B. pages 1a, 1b, 2 and 2a, 4a, 4b, 4c, 5, & 8 through 22.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19B, pages 1a, 1b, 2 and 2a, 4a, 4b, 4c, 5, & 8 through 22.

10. SUBJECT OF AMENDMENT: Physician reimbursement methodology change.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Michael J. Willden

13. TYPED NAME:
Michael J. Willden

14. TITLE:
Director, DHR

15. DATE SUBMITTED: 6-30-03

16. RETURN TO:
John A. Liveratti, Chief
DHCFP/Medicaid
1100 East William Street, Suite 102
Carson City, Nevada 89701

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: June 30, 2003

18. DATE APPROVED: February 2, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: May 8, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Linda Minamoto

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Assurances

These reimbursement methodologies are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204.

These rates comply with the requirements of Section 1902(a)(30) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency and quality of care.

Rate methodology and provider retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained.

Supplemental Payments for FQHCs/RHCs selecting the PPS methodology

FQHCs/RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for furnishing such services, that are an estimate of the difference between the payments the FQHC/RHC receives from MCE(s) and the payments the FQHC/RHC would have received under the BIPA PPS methodology. At the end of each FQHC's/RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS. The FQHC/RHC will be paid the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC/RHC will refund the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount is less than the total amount of supplemental and MCE payments.

Supplemental Payments for FQHCs/RHCs selecting the alternative methodology

FQHCs/RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services, that are an estimate of the difference between the payments the FQHC/RHC receives from MCE(s) and the payments the FQHC/RHC would have received under the alternative methodology. At the end of each FQHC's/RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the alternative methodology. The FQHC/RHC will be paid the difference between the amount calculated using the alternative methodology and actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the alternative amount exceeds the total amount of supplemental and MCE payments, the FQHC/RHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the alternative amount is less than the total amount of supplemental and MCE payments.

In the period before a prospective rate is fully implemented, interim payments will be based on the current Medicare audited core rates.

During the period January 1, 2001 to September 30, 2001, the State will pay current FQHCs/RHCs 100 percent of the average of their reasonable costs of providing Medicaid-covered services during fiscal year 1999 and fiscal year 2000, adjusted as outlined above to take into account any increase (or decrease) in the scope of services furnished during fiscal year 2001 by the FQHC/RHC.

3. Laboratory services will be paid at: lower of :
   1. Billed charges
   2. Maximum allowed by Medicare
   3. A fixed fee per unit value of the 1974 CRVS as modified by implementation of the Current Procedural Terminology, or
   4. Contracted Amount

4. EPSDT
   a.. Early and periodic screening: lower of a) billed charge, or b) fixed fee per unit value of the 1974 CRVS as modified; diagnosis and treatment: as indicated for specific services listed elsewhere in this attachment.
   b. Family planning services and supplies: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs.

5. Payments for services billed by physicians using Current Procedure Terminology (CPT) codes will be calculated using the April 1, 2002 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2002 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
   a. Surgical codes 10000-69999 will be reimbursed at 100% of the Medicare facility rate.
   b. Radiology 70000-79999 codes will be reimbursed at 100% of the Medicare facility rate.
   c. Medicine 90000-99199 and Evaluation and Management codes 99201-99999 will be reimbursed at 85% of the Medicare non-facility rate.
   d. Obstetrical services classified under CPT codes 59000-59999 will be reimbursed at 128% of the Medicare non-facility rate.
   e. Anesthesia services will be reimbursed at a fixed fee per unit value of the 1974 CRVS as modified.

   Newly developed CPT codes will be entered into the system using the Nevada specific unit value developed by Medicare. The 2002 Medicare Physician Fee Schedule conversion factor will be used to calculate payment. The maximum allowable will be established by multiplying the unit value and the 2002 conversion factor then paying the appropriate percentage based on the provider type, service type and CPT code range.

   If a code is billed that has no Nevada specific Medicare rate, the Division will determine if there is national Medicare pricing, if so the service will be paid at the appropriate percentage of that rate. If there is no national Medicare pricing, the Division will establish pricing based on similar services.

   Radiology and surgical services will be paid at an enhanced rate for recipients under the age of 21. This enhanced rate is calculated as follows:
   Surgical services will be the lesser of billed charges or 170% of the maximum allowable amount for the code billed. Radiology services will be the lesser of billed charges or 120% of the maximum allowable amount for the code billed.

6. Medical care and any other type of remedial care provided by licensed practitioners:
   a. Payment for services billed by a Podiatrist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
      1. Surgical codes 10000-69999 will be reimbursed at 74% of the Medicare facility rate
      2. Radiology codes 70000-79999 will be reimbursed at 88% of the Medicare facility rate
      3. Medicine 90000-99199 and Evaluation and Management codes 99201-99999 will be reimbursed at 66% of the Medicare non-facility rate.
   b. Payment for services billed by an Optometrist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or 85% of the Medicare non-facility rate, See also 12.d.,
   c. Payment for services billed by a Chiropractor will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
      1. Medicine 90000-99199 and Evaluation and Management Code 99201-99999 will be reimbursed at 70% of the Medicare non-facility rate
      2. Radiology codes 70000-79999 will be reimbursed at 32% of the Medicare facility rate.

d. Payment for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Surgical codes 10000-69999 will be reimbursed at 69% of the Medicare facility rate
2. Medicine 90000-99199 and Evaluation and Management codes 99201-99999 will be reimbursed at 74% of the Medicare non-facility rate.
3. Anesthesia services will be reimbursed at a fixed fee per unit value of the 1974 CRVS as modified.
4. Obstetrical services classified under CPT codes 59000-59999 will be reimbursed at 88% of the Medicare non-facility rate.

e. Payment for services billed by a Psychologist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or 74% of the Medicare non- facility based rate .

7. Home health care services:
   a. Intermittent or part-time nursing services provided by a home health agency: lower of a) billed charge, or b) fixed fee schedule.
   b. Intermittent or part-time nursing services when no HHA: lower of a) billed charge, or b) fixed fee per hour.
   c. Home health aide services provided by a home health agency: lower of a) billed charge, or b) fixed fee schedule.
   d. Equipment and appliances: retail charge less negotiated discount.
   e. Physical, occupational or speech therapy provided by a home health agency: lower of a) billed charge, or b) fixed fee schedule.
   f. Disposable supplies:
      1) If a supply item has a National Drug Code (NDC) number and is listed: lower of a) billed charge, or b) 90% of Average Wholesale Price (AWP) as indicated on the current listing provided by the First Data Bank plus a handling fee.
      2) If a supply does not have an NDC number, is not listed and Medicaid has established a published fixed fee: lower of a) billed charge, or b) fixed fee schedule.
      3) If a supply does not have an NDC number, is not listed and Medicaid has not established a published fixed fee: 70% of billed charge.
      4) Payments for disposable supplies for Medicare crossover clients will not exceed the upper limits at 42 CFR 447.304.
8. Private duty nursing services: audited billed charges.

9. Special clinic services: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs, therapy.
   a. Surgical codes 10000-69999 will be reimbursed at 69% of the Medicare facility rate
   b. Radiology codes 70000-79999 will be reimbursed at 100% of the Medicare facility rate
   c. Medicine 90000-99199 and Evaluation and Management codes 99201-99999 will be reimbursed at 60% of the Medicare non-facility rate.
   d. Anesthesia services will be reimbursed at a fixed fee per unit value of the 1974 CRVS as modified.
   e. Obstetrical services classified under CPT codes 59000-59999 will be reimbursed at 88% of the Medicare non-facility rate.

10. Dental services: lower of a) billed charge, or b) fixed fee per unit value for CDT codes. Services billed using CPT codes will be calculated using the April 1, 2002 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2002 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below
    a. Surgical codes 10000-69999 will be reimbursed at 100% of the Medicare facility rate.
    b. Radiology 70000-79999 codes will be reimbursed at 100% of the Medicare facility rate.

11. Therapy
    a.. Physical therapy: lower of a) billed charge, or b) the 2002 Nevada specific,non- facility based resource based relative value scale (RBRVS) unit values used by Medicare on April 1, 2002 multiplied by 85% of the 2002 Medicare Physician Fee Schedule conversion factor,

    b. Occupational therapy: lower of a) billed charge, or b) the 2002 Nevada specific,non- facility based resource based relative value scale (RBRVS) unit values used by Medicare on April 1, 2002 multiplied by 85% of the Medicare Physician Fee Schedule conversion factor,

    c. Services for individuals with speech, hearing, and language disorders: lower of a) billed charge, or b) the 2002 Nevada specific,non- facility based resource based relative value scale (RBRVS) unit values used by Medicare on April 1, 2002 multiplied by 85% of the 2002 Medicare Physician Fee Schedule conversion factor,

    d. Respiratory therapy; lower of a) billed charge, or b) the 2002 Nevada specific,non- facility based resource based relative value scale (RBRVS) unit values used by Medicare on April 1, 2002 multiplied by 85% of the 2002 Medicare Physician Fee Schedule conversion factor,

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